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STAFF DATA AND MATERIALS RELATED TO MEDICAID AND LONG-TERM CARE

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ROBERT J. DOLE, *Chairman*

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I. Key Points

While an estimated 60 to 80 percent of care extended to those in need of long-term care (LTC) services is provided on an informal basis by friends and family, about half of an estimated $25–30 billion in organized LTC services are financed with public funds, the bulk of these expenditures going to institutional services. The remainder of institutional LTC services are financed through direct, out-of-pocket payments. Private third-party insurance coverage for long-term care is virtually nonexistant.

The anticipated growth in the Nation's elderly population indicates that the future demand for long-term care services will far exceed the present level. At the same time, however, the relative size of the wage earning population to the at-risk groups will shrink substantially, severely limiting the public sector's ability to support such care through its tax base.

Nearly two-thirds of all LTC expenditures made through federally supported programs paid for institutional care provided in nursing homes. In FY 1982, approximately $13 billion was paid out through the medicaid program for institutional LTC services. Public expenditures have historically followed an expensive medically oriented approach to long-term care in spite of the fact that many impaired individuals are institutionalized because of a lack of nonmedical community-based support services which assist them in maintaining an independent existence. In recent years, however, increasing attention has been paid to the development of home- and community-based long-term care delivery systems as a more humane and cost-effective alternative to institutional LTC. In response to increased flexibility provided by Congress in the Omnibus Budget Reconciliation Act of 1981, most of the States are now experimenting through their medicaid programs with the design and implementation of these home- and community-based delivery systems for limited portions of their frail elderly and/or developmentally disabled populations. The long-range goal of these activities is the development of a rational, coordinated LTC delivery system, something that does not currently exist in this country.

Congress has mandated that these alternative delivery systems not increase total medicaid expenditures. On a per case basis, a 1977 GAO report found community-based care to be, in most instances, less expensive than institutional LTC services, with the exception of those individuals with high levels of disability. A subsequent GAO report cautioned that expanded home health coverage does not necessarily reduce nursing home expenditures. Thus, if in the short run these alternative systems are not to increase medicaid costs overall, the most critical—and difficult—task is to design a system which provides community-based services to individuals who would otherwise actually be institutionalized. How well States have been able to carry out this task is yet to be determined.

Given the anticipated growth in the demand for LTC, these alternative systems may have long-range cost-avoidance implications by decreasing the pressure for construction of more nursing home beds which would eventually be financed with public dollars. The assessment of the long-range impact on these medicaid projects was not addressed directly in the Omnibus Reconciliation Act of 1981 but merits further examination.

With respect to the provision of long-term care, no consensus yet exists as to what the appropriate roles and responsibilities should be for the public and private sector, the latter including the families of those individuals requiring long-term care. In addition, within the public sector, agreement has yet to be reached as to the relative responsibilities of the different levels of government—Federal, State, and local.

In examining Federal policies in the area of long-term care, the following issues are raised:

Should public support be targeted solely on those individuals unable to pay for needed LTC services, i.e., should some form of means-testing be required? What role should the families of individuals with LTC needs be expected to play? What role can the private sector play?

How can innovation in LTC continue to be fostered so that a rational delivery system can be developed as quickly as possible?

Should existing federally supported programs which finance LTC be consolidated to provide a more coordinated Federal approach to long-term care?

What social, ethical, and economic standards should be established for any LTC delivery system supported with Federal funds? For example, should Federal funds be used to finance the care of the developmentally disabled in large institutions?

Within the medicaid program, the following are issues to be addressed:

What is the current status and impact of the waiver programs authorized under Section 2176 of P.L. 97-35?

What has been the reaction to the Administration's recent interpretation allowing States to impose financial responsibility requirements on relatives of individuals receiving LTC benefits?

Should there be different treatment of the acute care and LTC portions of medicaid in any proposal to federalize medicaid?

II. Background

One of the most difficult social issues facing our Nation is how best to provide for the long-term needs of our frail elderly and disabled population. Long-term care refers to the broad array of medical and social support services that are required to meet the needs of the frail elderly and functionally disabled individuals in this country.

Providing for the needs of these vulnerable populations requires a substantial level of effort. Although it is estimated that 60 to 80 percent of the care received by the impaired elderly is provided by relatives and friends, at least 80 federally supported programs assist persons with LTC problems, either directly or indirectly through cash assistance and other support activities. Expenditures for long-term care related services through federally assisted programs total over $13 billion in FY 1980, paying the bill for over half of the over 1.3 million individuals in nursing homes, nearly 87 percent of which were elderly (those over the age of 65) Americans.

While substantial resources are presently being directed toward long-term care, demographic trends indicate that the future demand for such care by this Nation's elderly population will be even greater than at present. The latest projections by the U.S. Bureau of the Census estimate that, by the year 2050, 21.7 percent of the population is likely to be over age 65, up from the present 11.4 percent. In addition, female life expectancy is projected to rise from the current 78.3 to 83.6 years, with male life expectancy up from 70.7 to 75.1. Most importantly, with respect to long-term care, the percent of the total population who are 85 years or older will increase from 1 percent to 5.2 percent. In light of the strong correlation between age, degree of disability, and utilization of long-term care, this "graying" of our population portends a substantial increase in the demand for such services.

Projecting current age-specific nursing home use rates to population predictions for the years 2000 and 2030, one study by the Department of Health and Human Services' Health Care Financing Administration (HCFA) estimated that the present number of nursing home residents would increase by 54 percent and 132 percent for those years, respectively. To the extent that certain other factors—such as increasing divorce rates, declining birth rates, and the increased participation of women in the labor force—may reduce the future ability or willingness of families to care for their elderly members, these use rates may increase, thus expanding this estimate of future institutionalization.

The problems created by this increase in the demand for long-term care will likely be exacerbated by other demographic changes anticipated for our Nation. The Census Bureau also reports that the ratio of the number of individuals of working age (18 to 64) to individuals of retirement age (65 and over) will drop from its

present level of 5.4 to 1 to 2.6 to 1 by the year 2050. Thus, while the relative size of the elderly population will nearly double, the ability of the wage earning segment of the population, as we define it today, to support their needs is expected to be cut in half.

The demand for long-term care can be expected to change not only quantitatively, but also qualitatively. Pressure is mounting to move away from the traditional, medical-model institutional approach to caring for the needs of the frail elderly and the physically and mentally disabled to more open, community-based approaches which maximize the independence of the individual. Many observers believe that the chronically ill elderly do not need the medical model, but rather a variety of health/social services.

Trends in both the size and nature of the demand for long-term care are compelling public policymakers to search for answers in current efforts to rationalize the delivery and payment of long-term care services for the elderly and disabled. The profile of public expenditures for long-term care make the Federal-State medicaid program the logical focus for such a review.

III. Long-Term Care Expenditures

While the bulk of care received by the impaired elderly is provided by relatives and friends, the financing of services in more formal arrangements in which some fee is charged has become a major governmental responsibility. Publicly financed services have traditionally been designed around the medical model, with the bulk of public expenditures going toward costly nursing home care. In 1981, the national bill for nursing home care reached $24.2 billion. Of this amount, government expenditures accounted for nearly 56 percent, private payments the remaining 44 percent. Of these private expenditures, 97 percent are direct out-of-pocket payments, while only 2 percent are from third-party insurance benefits, and another 1 percent from other types of private payments.

About half of all nursing home expenditures—both public or private—are made through the Federal-State medicaid program. Payments for these institutional long-term care services totalled nearly $13 billion in fiscal year 1982, accounting for 43 percent of all medicaid service expenditures. In contrast, only $495 million in medicaid expenditures were made for home health service, representing only 2 percent of total program payments.

Institutional long-term care expenditures represent not only a large, but also a rapidly growing portion of medicaid expenditures. During the 5-year period from fiscal year 1977 to fiscal year 1982, these expenditures have increased from $6.1 billion to nearly $13 billion, at an annualized rate of increase of 16.4 percent.

Medicaid pays for institutional long-term care services provided in three types of facilities:

(1) Skilled nursing facilities (SNF's), which provide care to patients requiring medical or skilled nursing care, or rehabilitative services. These facilities must have nursing services available on a 24-hour basis from at least one full-time registered nurse;

(2) Intermediate care facilities (ICF's), which provide services to individuals who didn't require as high a degree of care as that provided by hospitals of SNF's, but who require health-related care and services beyond that of room and board; and

(3) Intermediate care facilities for the mentally retarded (ICF's-MR), which are ICF-level facilities.

A 1980 National Nursing Home Survey revealed that there were about 23,000 nursing homes in the United States. Nearly 15,000 or 75 percent of all nursing homes participated in medicaid or medicare. Data from a 1977 survey indicate that nearly half of these facilities had only ICF-level beds, slightly more than a fifth had only SNF-level beds, and approximately 30 percent had both SNF- and ICF-level beds. The 25 percent of nursing homes which did not participate in either medicare or medicaid were mainly small facilities, representing only 12 percent of all nursing home beds.

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Of medicaid's fiscal year 1982 total expenditure of $13 billion for institutional long-term care, $4.38 billion or 33 percent was paid to SNF's. $4.98 billion or 38.4 percent was paid to ICF's, and $3.61 billion or 27.8 percent went to ICF's-MR. It should be noted that while medicaid expenditures for SNF's and ICF's rose by 9.8 percent and 10.2 percent, respectively, from fiscal year 1981 to fiscal year 1982, expenditures for ICF's-MR rose twice as fast, increasing by over 22 percent.[1]

Although elderly individuals covered by medicare have a high incidence of conditions requiring long-term care, medicare coverage of such services is relatively limited. This is due to the fact that the medicare nursing home benefit was intended to provide acute care coverage for post-hospital nursing services, not long-term services. This was seen as a less costly alternative for persons who would otherwise require continued hospital services.

In 1981, medicare expenditures for skilled nursing facility care and home health services amounted to $422 million and $1 billion, respectively. Despite the existence of 100 days of medicare coverage of skilled nursing facility care per spell of illness, that medicare payments for skilled nursing facility care are quite small, is a proportion of total expenditures for these services accounting for only 2 percent of total nursing home revenues. This is due to the allowing factors:

Qualifying conditions; i.e., the patient must have had a prior hospital stay of at least 3 days and must require skilled care on a daily basis for treatment related to a condition for which the beneficiary was hospitalized;

Inconsistent level of care interpretations by medicare fiscal intermediaries frequently result in the denial of medicare coverage of SNF care and the awarding of different benefits to similar patients.

Medicare defines spell of illness as beginning with the first day an individual is admitted to a hospital or SNF and ending at the close of a period of 60 consecutive days during which the individual is not institutionalized. For those individuals who would be admitted to an SNF for an extended period of time, medicare coverage would be limited to the first 100 days of the stay.

Medicare's limited coverage of SNF care has resulted in access problems. In areas which medicaid and private demand is insufficient to support a market, SNF's do not exist, this is particularly true in rural areas. In many areas, unused hospital beds serving as "swing beds" would be available to compensate for this lack. It is estimated that nationwide only about two-third of SNF's participating in medicaid also participate in medicare. The participation rates vary from State to State, from a low of 3.5 percent of all SNF beds in Arkansas being certified for medicare coverage to 100 percent medicare certification in sixteen States. To address this problem, many States require that SNF's participating in medicaid also participate in medicare. In thirteen of the sixteen States with full participa-

[1] Some portion of this increase may be due to more accurate reporting by some States that began recently to separate out the ICF-MR expenditures from their payments to regular ICF's.

tion, the State has mandated that SNF's certified for medicaid must also be certified for medicare.

It should be noted that, even though its total share remains small, home health care has become one of the fastest growing components of the medicare and medicaid programs. For example, medicare home health outlays rose 32.7 percent per year from 1975 to 1981. The number of medicare home health visits has also grown—from 8.1 million in 1974 to 22.4 million in 1981. Although it spends less than medicare on home care, the medicaid program is also experiencing an increase in the amount of resources devoted to home health care. In 1972, home health visits were provided to about 113,000 persons under medicaid. For 1981, it is estimated that more than 400,000 persons were recipients of home health benefits under medicaid.

IV. Federal Initiatives in Long-Term Care

In recent years, the Federal Government has sponsored various activities that have resulted or are intended to result in policy changes in the area of long-term care. The most important of these are described briefly below.

A. LTC Channelling Grant Demonstration Program

The Department of Health and Human Services has followed up on earlier LTC experiments by sponsoring a major demonstration of the effectiveness of LTC "channelling" programs. The term "channelling" refers to organizational structures and systems to coordinate available long-term care resources and manage them effectively on behalf of clients. Ten demonstration sites are currently participating in this program, which was begun in 1980. Results from these experiments are expected to be available beginning in March 1984.

B. AOA Model Project Activities

Under its Model Project Program, the Administration on Aging (AOA) funds a wide variety of demonstration activities, many of which relate to long-term care. At present, over 70 different demonstrations are being or have been carried out in over 25 subject areas, including respite care, adult day care, and hospice services. AOA also supports 11 LTC gerontology centers which are designed to develop and disseminate information on innovative, cost-effective LTC delivery models to professionals in the field.

C. Medicaid Home- and Community-Based LTC Waiver Projects

Congress extended to States significantly greater flexibility in developing alternative LTC delivery systems by including Section 2176 in the Omnibus Reconciliation Act of 1981 (ORA). This section granted the Secretary of the Department of Health and Human Services the authority to waive certain medicaid requirements to allow States to set up home- and community-based long-term care delivery systems for medicaid-eligible individuals who were at risk of institutionalization. The flexibility to modify certain program eligibility requirements which promoted institutionalization was provided to States, as was the ability to provide a broad range of community-based services not normally covered under medicaid. The States' response to this statutory provision is described later in this report.

D. Special Eligibility Provisions for the Disabled

The Department of Health and Human Services has also used the section 2176 waiver authority to allow States to apply for a

"model waiver." Under these "model waivers" a State may provide medicaid eligibility and community-based long-term care services to no more than 50 blind or disabled individuals who would otherwise be eligible for medicaid only if they were patients in an institution. The impetus for this approach was generated by the case of Katie Beckett, an institutionalized disabled child whose parents sought medicaid assistance to care for her at home. The Department has also set up an internal review board to review similar requests for medicaid coverage on a case-by-case basis.

In addition, following the Katie Beckett incident, section 134 of Public Law 97-248 gave States the option of extending medicaid coverage to disabled children living at home or in the community who require hospital or nursing home level care which could be provided outside these institutions, if the cost of providing these services at home does not exceed the cost of the institutional care. Because States may be concerned about the potential for greatly increasing program enrollment if they opted for this approach, only one State—Idaho—has implemented this option.

E. Medicaid Transfer of Assets Prohibition and Lien Provisions

In 1980, Congress passed legislation to allow States to target medicaid benefits to those in greatest financial need by denying medicaid eligibility for a certain period of time to individuals who transferred assets at less than fair market value. This policy change attempted to avoid situations in which an individual with substantial financial resources and in need of long-term care services is able to transfer these resources to a relative and then receive medicaid coverage of costly nursing home care.

The 1980 legislation excluded the individual's home from the definition of the "resources" which could not be transferred for less than fair market value. A subsequent provision in Public Law 97-248, the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) allowed a State to include the household if it established a transfer of assets provision. TEFRA also allowed States to impose liens on the homes of nursing home residents for whom medicaid payments were being made. These liens cannot be closed until the home is sold or the recipient dies, or while certain nondependent children remain in the home.

F. Medicaid Family Responsibility Ruling

In February 1983, the Health Care Financing Administration (HCFA) revised its interpretation of a longstanding Federal policy which prohibited States from requiring children to contribute to the cost of caring for their medicaid-eligible parents in nursing homes.

HCFA's new interpretation allows States to impose such a cost-sharing requirement if it is part of a broader State family responsibility policy not specifically focused on medicaid program eligibility. Only one State—Idaho—has used this new interpretation to implement a family responsibility requirement, although the Georgia Legislature had previously passed a bill allowing the State to do so in the event the Federal prohibition against such a policy was removed. Because the legal basis for HCFA's interpretation has been

seen by many as questionable, more States have not implemented similar policies in part because they fear becoming embroiled in a law suit challenging HCFA's ruling.

G. Prepaid Capitation Demonstrations

Under the general research and demonstration authority provided by section 1115 of the Social Security Act, the Health Care Financing Administration (HCFA) is sponsoring several research activities which should provide valuable findings which will influence the development of LTC financing and delivery systems.

In response to a special solicitation for proposals to implement innovative medicaid arrangements which promote competition, HCFA has awarded a grant to the State of Minnesota to test the feasibility of providing all its medicaid benefits, including long-term care services, on a prepaid capitated basis. The State's initial design for that approach is expected to be submitted to HCFA within the next few months.

In addition, HCFA is also providing grant support for the development of a comprehensive prepaid service plan for medicare and medicaid recipients at one demonstration site in each of the following four States: California, Minnesota, New York and Massachusetts. At each of these sites, organizations referred to as "social/health maintenance organizations" (SHMO's) will provide both acute and long-term care services to medicare and medicaid recipients for a predetermined monthly fee. These experiments are expected to provide important information concerning the development of actuarially sound capitation rates and the benefits derived from the integration of medicare and medicaid coverage by a centralized care provider.

V. State Initiatives in Long-Term Care

Faced with serious fiscal problems in recent years, nearly all States have redoubled their efforts to control the growth in their medicaid programs, which in some States had represented their largest and most rapidly growing budget item. Given the substantial portion of medicaid payments which are made for long-term care services, it is not surprising that significant effort has been directed toward controlling this segment of the program. Efforts made by States to control medicaid expenditures in the long-term care area may be categorized as follows:

Changing medicaid eligibility criteria;
establishing incentives for increasing private responsibility for caring for individuals in need of long-term care;
modifying nursing home reimbursement policies; and
development of alternatives to institutional care.

Each of these is discussed in turn.

A. Medicaid Eligibility Criteria

Contrary to popular belief, or perhaps widespread fears, States on the whole do not appear to have resorted to widespread reductions in medicaid eligibility as a means of controlling program costs. Data collected by the National Governors' Association on over 2,000 medicaid policy changes initiated by individual States from mid-1978 to 1982 indicate that 1,400 described changes which restricted program coverage, while 600 expanded the program. Of the 1,400 reported medicaid policy changes which decreased the scope of States' programs, only 5 percent were directed at restricting eligibility policy. By contrast, over one-third of the policy changes made by individual States which expanded the program were in the eligibility area.[1]

Several of the eligibility changes which have recently been made by a significant number of States have a major impact on the number of individuals eligible for long-term care. The majority of States have adopted policies in the past several years which take advantage of the increased latitude provided in Federal law which allow them to deny medicaid eligibility to individuals who transferred at less than fair market value resources which otherwise would have made them ineligible for medicaid. It is likely that States will also move to implement the additional authority provided by the Tax Equity and Fiscal Responsibility Act of 1982, which extends the prohibition on the transfer of assets to the indi-

[1] Some care should be used in interpreting these data for in the classification schedule used to catalogue this information, action taken by a State to increase the levels of AFDC cash grants by 5 percent would have been recorded as an expansion of program eligibility criteria, even if the cost of living in that State may have increased by 10 percent. The criterion for classifying a policy change as expansionary was thus not whether it is more generous in real terms, but rather if it is more expansive than the State's previous policy.

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vidual's home and also allows States to attach a lien upon the real property of medicaid recipients permanently institutionalized in long-term care facilities.

The rationale for States' implementation of these policies is that; given scarce resources, it becomes necessary to develop means of targeting services to best achieve the original purpose of the medicaid program, namely, caring for the health care needs of the truly indigent. Because the means-tested medicaid program is virtually the only public program which provides substantial assistance in paying for costly long-term care, individuals in need of such services and unable to shoulder the heavy financial burden are required to pauperize themselves in order to pay for expensive nursing care.

Critics claim that the root of this problem lies not with medicaid, its policies, or the individual's wishes to leave some legacy for his or her family. It lies with the system, or the lack of it, which makes medicaid the only real protection these people have.

On a more positive note, several States have in the past year increased their income eligibility standards for individuals residing in the community and in need of long-term care services to the higher levels allowed for nursing home standards. States were able to make this change under the community-based long-term waiver authority provided by section 2176 of Public Law 97-35, which will be discussed in greater detail later. As the majority of States implementing this expanded eligibility policy did not have a medicaid medically needy component, these changes will substantially increase the number of individuals in these States with access to medicaid-financed community LTC services. In most instances, the only way these individuals could previously have been covered under medicaid was by entering a nursing home.

Several States have also used the flexibility provided by section 2176 to exclude the income of spouses or parents in determining the medicaid eligibility of individuals needing long-term care and living at home. This waiver of the normal income "deeming" requirements has the effect of offsetting existing eligibility policies which only allow this income to be disregarded—and therefore make some individuals eligible for medicaid coverage—when these persons have been institutionalized for 1 month.

As discussed earlier, the Department of Health and Human Services has also used the section 2176 waiver authority to allow States to apply for "Model Waivers," under which a State may provide medicaid eligibility and community-based long-term care services to no more than 50 blind or disabled individuals who would otherwise be eligible for medicaid only if they were patients in an institution. To date, two States—Mississippi and Michigan—have received approval of their model waiver requests.

In sum, it may be said that the effect of the major State-initiated medicaid eligibility changes affecting long-term care services has been to require certain individuals to utilize their own resources to pay for nursing home care and, in certain instances, to make community-based services accessible to a greater number of individuals.

B. Establishing Incentives for Increasing Private Responsibility for Caring for Individuals in Need of LTC

Several States have in recent years developed policies outside of their medicaid program which are designed to foster the participation of others in the care of the elderly and disabled. The Iowa Legislature in 1982 passed a statute allowing State income tax deductions to individuals for expenses incurred for maintaining an elderly relative in the home. Deductions are limited to $5,000 in expenses for the care of a parent or grandparent of the taxpayer who is unable to live independently and who would be eligible for medicaid if living in a nursing home. Oregon has also adopted legislation providing tax incentives for care of the elderly, while the Kentucky and Minnesota Legislatures debated elderly care tax incentive proposals last year but did not pass legislation. New Jersey and Massachusetts also had tax incentive proposals pending before their legislatures.

Related legislation was passed by the Idaho Legislature in April 1981. This bill established a new medical assistance account into which relatives of nursing home patients may make voluntary contributions toward the State share of nursing home costs. Such contributions may be claimed as deductions for State income tax purposes.

A recent New York bill would establish demonstration programs for informal care-giver support. These programs would be designed to strengthen the ability of care-givers to provide care for the elderly. The assistance to be given would include the development and coordination of care-giver networks, information and referral to care-givers about resources, and services. In addition, at least 28 States have applied under the waiver authority of section 2176 of Public Law 97-35 for permission to provide respite care services under medicaid for families caring for elderly disabled individuals.

In certain instances, approaches have been developed to directly assist the elderly in staying in the community. The State of Virginia granted local governing bodies the authority to exempt the elderly totally or partially from real estate taxes. Those eligible for exemptions are generally individuals with incomes less than $18,000 and combined financial worth of less than $65,000.

C. Nursing Home Reimbursement Policies

A wide variety exists in the characteristics of the nursing home supply from one State to another, and also the amounts that are paid for care provided in these facilities. In Louisiana, Oklahoma, and Tennessee, only about 2 percent of the patients are in skilled nursing facilities and 98 percent in intermediate care facilities compared with 89 percent in SNF's in Florida. These large differences in the proportion of SNF and ICF beds in the nursing home supplies of different States raise the question as to whether these differences actually reflect differences in the care needs of the populations within the two types of facilities or differences in States' interpretations of SNF/ICF guidelines. As a result, some have suggested that the distinction between the two levels be eliminated.

With respect to reimbursement levels, a survey conducted in 1981 by the National Governors' Association found that medicaid

SNF per diem rates ranged from $71.56 in Hawaii and $67.63 in New York down to $26.36 in South Dakota and $25.53 in Arkansas. Similarly, ICF per diem rates ranged from $50.87 in the District of Columbia to $22.57 in Nebraska and $22.84 in Illinois.[1] Services provided in Intermediate Care Facilities for the Mentally Retarded (ICF's-MR) were in some cases particularly expensive, with per diem rates ranging from $167 in Alaska and $123 in Massachusetts to $34.37 in Washington and $24.62 in Illinois. Between 1979 and 1981 SNF and ICF rates increased at an annual rate of about 11.6 percent. ICF-MR rates increased at a much higher rate during that period—18.6 percent per year.

In an effort to gain greater control over future increases in nursing home costs, the majority of States have moved to prospectively determined reimbursement approaches to pay for these services. For SNF care, twenty-five States currently utilize facility-specific prospective systems, while another 5 use a prospective rate set for individual classes of beds. Another six States combine prospective and retrospective elements in their reimbursement system.[2] A total of 39 States pay for ICF services based upon some form of prospective reimbursement system.

A requirement for a medicaid admission to a nursing home in half of the States is some form of preadmission screening or prior authorization. These preadmission screening programs attempt to identify those potential nursing home residents who could be maintained in the community at a cost below that of nursing home care. Virginia's preadmission screening program in effect covers more than the actual medicaid population by stipulating that medicaid coverage will not be available to individuals who enter a nursing home as a private pay patient and then later apply for medicaid unless the individual has undergone a preadmission assessment.

As suggested in a recent GAO report, the proliferation of these screening programs and the development of community based long-term care services can be expected to have their most direct effect on nursing homes not through a reduction in their census but rather through a change in the level of the average nursing home resident's disability. If those individuals with lower levels of disability are identified through prescreening and kept in the community, the population entering facilities are likely to be on the whole more severely disabled and require a greater degree of care. As lower cost patients are replaced by those requiring greater amounts of care, pressure may be exerted to increase rates.

In an effort to address this issue and to better target reimbursement to the level of care rendered, several States have moved to reimbursement mechanisms linked to either patient-specific requirements or case mix measures. Nine States currently have such systems. For example, Massachusetts pays SNF's 120 percent of its regular SNF rate for each patient they accept who has been backed up in a hospital for 150 days or more. This higher rate is paid the

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[1] Alaska, which did not report its SNF and ICF rates separately, is a particularly high-cost State, with an average per diem of $97.39 for both levels of care.

[2] It should be noted that Public Law 97-248 directed the U.S. Department of Health and Human Services to study the possibility of establishing a prospective reimbursement system for SNF care financed under medicare. This report, which may have implications for the medicaid reimbursement policies, is due to be presented to Congress by December 1, 1983.

facility for 1 year. The following year the rate drops to 110 percent and the next to the normal SNF rate. In Washington, activities of daily living (ADL) scores are used to adjust rates, while in Ohio and Illinois, sophisticated patient evaluation and cost schemes are utilized. Maryland is also considering implementation of a patient-based approach.

D. Development of Community-Based Services as an Alternative to Institutional Care: Section 2176 Programs

In addition to refining their nursing home reimbursement methodologies, many States are also pursuing a broader solution to the long-term care problem through the development of home- and community-based long-term care services as alternatives to costly nursing home care. Some States had been experimenting with establishing alternative delivery LTC systems a number of years, first under the medicaid research and demonstration waivers, then under the National Long-term Care Channelling Demonstration Programs.

A major movement by the States to develop alternative LTC programs was spurred by section 2176 of Public Law 97-35, the Omnibus Reconciliation Act of 1981. This provision authorized the granting of waivers to State medicaid agencies to develop programs to finance home- and community-based care for medicaid recipients who would otherwise require nursing home care. The statute allows States to cover under their waiver programs a broad array of services not previously reimbursable under medicaid. In addition, the statewideness and comparability requirements of the medicaid program could be waived to allow States to target their waiver programs on certain vulnerable populations or on specific geographic areas within a State. In an attempt to control against excessive costs, the statute requires that the State provide assurances that the average per capital medicaid expenditure for the waivered population does not exceed what it would have been without the waiver.

States' response to this waiver authority has been striking. As of the beginning of July 1983, 44 States had submitted 86 waiver requests. Of these, 35 States have received approval of 45 requests, while 30 were still pending, 6 were disapproved, and 5 had been withdrawn. A status report on waiver requests as of the end of September 1983, is provided in Attachment A of this report.

Substantial variety exists across the programs being implemented under the section 2176 waiver authority. An analysis of the 60 waiver requests either approved or pending as of mid-May indicated that nearly half of them were targeted solely upon the aged and physically disabled population, while a third focused exclusively on the developmentally disabled population. The remaining waiver programs proposed to cover combinations of these two groups as well as mentally ill recipients. A wide range of services have been requested, with case management, adult day health, habilitation, respite care, and homemaker services being included in about half the applications. The scope of the different programs vary widely. For example, the State of Montana received a waiver to deinstitutionalize the patients in two specific ICF's-MR, while other States

are planning to phase-in statewide programs for their elderly populations.

Because the development of comprehensive community-based long-term care programs is still a relatively recent phenomenon, States must do more than simply adopt a policy providing medicaid coverage of additional services to successfully implement their waiver programs. In most cases, States must also develop:

Standards for licensing or approving providers of home and community-based services;

assessment and case management systems which allow them to identify those individuals at risk of institutionalization and track the services they recieve in the community; and

guidelines for monitoring the quality of care delivered by providers of community-based services.

Perhaps the most difficult challenge facing States developing such alternative delivery systems is to provide these services without increasing total medicaid costs. As noted earlier, a 1977 GAO study concluded that for, all but the severely disabled, long-term care could often be provided, on an individual basis, less expensively in the community than in a nursing home. However, Federal regulations implementing the statutory requirement that per capita medicaid costs not increase as a result of the waiver also reflect a concern referenced in the conference committee report accompanying Public Law 97-35. The regulations therefore require that total medicaid costs not be increased as a result of the waiver.

The savings States must realize to offset the increased expenditures for waiver program services must come for the most part from a reduction in the number of nursing home bed days for which medicaid pays.[1] The critical variable influencing a waiver program's effect on a State's total expenditures is therefore the State's ability to target the delivery of community-based services on those individuals who, in the absence of the waiver, would have entered a nursing home. The experience of earlier demonstration efforts reveal this to be a very difficult task. Evaluations of these efforts indicate that not more than 20 percent of control populations used in these demonstrations/experiments actually entered a nursing home. That is, in these previous demonstrations, only about 1 out of 5 of the individuals with the same characteristics as those of the group receiving waiver services but who did not receive these services were actually admitted into a nursing home.

That only a limited portion of the target population actually entered a nursing home in the absence of the community-based programs may reflect factors other than an individual's need for nursing home care. For example, in many areas of the country waiting lists resulting from nursing home bed shortages made admission to a home very difficult. Whatever the reasons, these results highlight the difficult task States face in making these programs immediately cost-effective. The interim final Federal regulations governing the program, however, require annual reviews of each State's spending levels, both projected without the waiver program, and the actual levels with the program. Proposed final regulations cur-

[1] In certain cases, savings may be derived from moving into the community individuals backed up on hospitals while awaiting nursing home placement.

rently under review by OMB would disallow Federal funding for any expenditures which exceed projected levels.

These expenditure comparisons evaluate the program only on a short term (i.e., year-to-year) basis. As discussed earlier, however, the problem these programs hope to address is in fact a long-term one, with the problem becoming increasingly more serious in future years. Critics argue that a strict short-term expenditure oriented evaluation of the program will never allow the development of a coordinated community-based long-term care and delivery system to develop. It is believed by these critics that in the long run, the existence of such alternative services will deflate to some extent the growing pressure for construction of greater numbers of nursing home beds which will ultimately be filled and paid for with public dollars.

The Department of Health and Human Services has recently awarded a contract to evaluate the effectiveness of the programs authorized under section 2176 of Public Law 97-35. The proposed scope and findings of this evaluation effort should be monitored closely because of the significant implications of these programs for short-term Federal expenditure levels and for the Nation's growing long-term care needs.

VI. Pending Legislative Proposals

In recent years, the focus of the major legislative proposals in the area of long-term care have been upon the expansion of community-based services and/or the consolidation of the principal federally supported programs financing long-term care into one integrated program. The following Senate bills addressing long-term care and relating to programs within the jurisdiction of the Committee on Finance have been introduced in the 98th Congress.

(1) S. 176, sponsored by Senators Inouye (D., Hawaii), and Matsunaga (D., Hawaii). This is a proposal to provide gerontological nurse practitioner services under medicare Part B.

(2) S. 410, sponsored by Senators Inouye (D., Hawaii), DeConcini (D., Ariz.), and Packwood (R., Oreg.). This is a proposal to provide medicaid and medicare coverage of community nursing centers.

(3) S. 1244, The Senior Citizens Independent Community Care Act, sponsored by Senators Packwood (R., Oreg.), Andrews (R., N. Dak.), Bradley (D., N.J.), Burdick (D., N. Dak.), Cochran (R., Miss.), Hart (D., Colo.), Heinz (R., Pa.), Inouye (D., Hawaii), Lautenberg (D., N.J.), Matsunaga (D., Hawaii), Melcher (D., Mont.), Moynihan (D., N.Y.), Percy (R., Ill.), Pressler (R., S. Dak.), Randolph (D., W. Va.), Riegle (D., Mich.), Sasser (D., Tenn.), Stafford (R., Vt.), Wallop (R., Wyo.), and Zorinsky (D., Nebr.). This is a proposal to provide community-based long-term care services under the medicare program.

(4) S. 1540, The Community Home Care Services Act of 1983, sponsored by Senators Hatch (R., Utah), Kennedy (D., Mass.), and Hawkins (R., Fla.). This bill would provide for coordination of home health services provided by several federally supported programs and would allow States to expand coverage of home- and community-based services under their medicaid programs.

(5) S. 1614, The Health Care Coordination Act of 1983, sponsored by Senators Heinz (R., Pa.), Bradley (D., N.J.), Hatch (R., Utah), and Packwood (R., Oreg.). This is a proposal to coordinate the provision of acute and long-term care for individuals eligible for both medicare and medicaid.

Attachment A

Status Report on Medicaid Home- and Community-Based LTC Waiver Programs as of September 30, 1983

	Home- and community-based services				
	Received	Pending	Approved	Withdrawn	Disapproved
Total waivers	100	38	51	5	6
Total States submitting requests	46				
Total States with approved waivers	38				
Total new requests	2	(1)	(1)	(1)	(1)
Total new approvals	3	(2)	(2)	(2)	(2)

[1] In addition, 2 modifications to an existing waiver were received.
[2] In addition, 2 modifications to an existing waiver were approved.

PUBLIC LAW 97-35, SECTION 2176 WAIVER REQUESTS FOR HOME- AND COMMUNITY-BASED SERVICES

Description of home- and community-based services and date of initial request

[All services will be provided as an alternative to institutional care]

State		Status
Alabama (3 requests)	To provide rehabilitation services (excluding room and board) to MR/DD individuals. (Aug. 5, 1982).	Disapproved (Dec. 17, 1982).
	To provide rehabilitation services (excluding room and board) to MR/DD individuals (revised). (Jan. 13, 1983).	Approved (Mar. 3, 1983). Effective (Oct. 1, 1982).
	To provide case management services, homemaker services, personal care services, adult day health services and respite care services to eligible medicaid beneficiaries who require ICF/SNF care. (Aug. 31, 1983).	Under review.
Alaska	To provide for the aged and disabled, adult residential care, adult foster care, home health nursing, home health aide, personal care attendant, homemaker, respite care, adult day care, and physical modifications to the home; and to provide for the developmentally disabled, as additional alternatives, specialized foster care, group home services, respite care, vocational skills training and in-home normalized living training. (Jan. 14, 1983).	Additional information requested.
California (6 requests)	To provide case management, homemaker and personal care services to aged and disabled beneficiaries. (Dec. 18, 1981).	Disapproved (Mar. 18, 1982).
	To provide homemaker, home health aide, adult day health, habilitation, respite care services, personal support, transportation and regional center direct client support services to mentally retarded beneficiaries. (Dec. 18, 1981).	Disapproved (Mar. 18, 1982).

PUBLIC LAW 97–35, SECTION 2176 WAIVER REQUESTS FOR HOME- AND COMMUNITY-BASED SERVICES—Continued

[All services will be provided as an alternative to institutional care]

State		Status
	To provide homemaker, home health aide, adult day health, habilitation, respite care services, personal support, transportation and regional center direct client support services to mentally retarded beneficiaries. (Apr. 6, 1982).	Approved (Nov. 1, 1982). Effective (July 1, 1982).
	To provide case management, homemaker, home health aide, personal care, respite care and transportation services to mentally ill beneficiaries. (May 14, 1982) (DMH).	Approved (Dec. 8, 1982). Effective (Dec. 8, 1982).
	To provide case management, home health aide services, 24-hour nursing services, minor physical adaptations to home, utility coverage and respite care to individuals who would otherwise require an acute level of care. (Mar. 30, 1983).	Additional information received.
	To provide case management, adult social day care, housing assistance, in-home supportive services, respite care, transportation, meal services, protective services and special communications to individuals who would otherwise require placement in a SNF or ICF. (Mar. 30, 1983).	Approved (June 17, 1983). Received effective (July 1, 1983).
Colorado (3 requests)	To provide case management, homemaker, personal care, adult day health, respite care services, Meals on Wheels, nonmedical transportation, minor home modifications and electrical monitoring/communication devices to aged and disabled beneficiaries. (Apr. 6, 1982).	Withdrawn (June 9, 1982).
	To provide case management, homemaker, personal care, adult day health, respite care services, Meals on Wheels, nonmedical transportation, minor home modifications and electrical monitoring/communication devices to aged and disabled beneficiaries. (July 16, 1982).	Approved (Aug. 17, 1982). Effective (July 1, 1982).
	[3] Modification to waiver approved on Aug. 17, 1982. Request to delete "Meals on Wheels" as a covered service under waiver. (Feb. 25, 1983). Approved (Apr. 26, 1983).	
	To provide personal care, respite care and nonmedical transportation to mentally retarded and mentally ill beneficiaries and case management and habilitation services to mentally retarded beneficiaries. (May 14, 1982).	Approved (Jan. 6, 1983). Effective (Oct. 1, 1982).
Connecticut	To provide case management, occupational therapy, homemaker, companion, chore, Meals on Wheels, day care, transportation and mental health counseling in the home to aged and disabled beneficiaries. (June 10, 1982).	Approved (Dec. 10, 1982). Effective (Oct. 1, 1982).
Delaware	To provide case management, day habilitation, residential habilitation, respite care, and other services to individuals who would require an ICF/MR level of care. (Feb. 22, 1983).	Approved [2] (Sept. 27, 1983). Effective (July 1, 1983).
Florida (3 requests)	To provide case management, adult day health, and respite care services to the mentally retarded, aged and disabled; and homemaker, personal care services, counseling, escort, health support services and placement services for adults to the aged and disabled; and developmental training services, diagnostic and evaluation services, family placement, training and therapy services and transportation to the mentally retarded. Two requests. (Dec. 25, 1981).	Approved [2] (Apr. 21, 1982). Effective (Apr. 1, 1982).
	[3] Modification to waivers approved on Apr. 21, 1982. Request to change effective date from Jan. 1, 1982 to Apr. 1, 1982. (May 4, 1983). Approved [2] (June 7, 1983).	
	To provide case management, diagnosis and evaluation, developmental training, family placement, training and therapy, respite care and transportation to developmentally disabled individuals who would otherwise require the level of care provided in an ICF/MR. Model waiver. (July 28, 1983).	Under review.

PUBLIC LAW 97–35, SECTION 2176 WAIVER REQUESTS FOR HOME- AND COMMUNITY-BASED SERVICES—Continued

[All services will be provided as an alternative to institutional care]

State		Status
	To provide case management services, medical therapeutic, specialized homemaker/home management services, and personal care services to blind, disabled or aged individuals who would otherwise require the level of care provided in a SNF or ICF. Model waiver. (July 28, 1983).	Under review.
Georgia (2 requests)	To provide home health aide, personal care, physical, occupational and speech therapy services, nursing services, special medical supplies, equipment and appliances, planned therapeutic activities, home-delivered meals, and medical social services to aged, disabled and mentally retarded beneficiaries. (Dec. 2, 1981).	Approved (June 7, 1982). Effective (Oct. 1, 1981).
	[3] Modification to waiver approved on June 7, 1982. Request to change per capita estimates for fiscal year 1983 and 1984, based on first year's experience (Feb. 22, 1983) Under review.	
	To provide case management services to optional categorically needy individuals under 21 years of age and having a diagnosis of spina bifida who have been under long-term care within the last 12 months. Model waiver. (Aug. 31, 1983).	Under review.
Hawaii (3 requests)	To provide case management, homemaker, physician extender, home health aide, personal care, adult day health, habilitation and respite care services to mentally retarded beneficiaries. (Mar. 19, 1982).	Approved (Oct. 28, 1982). Effective (Oct. 28, 1982).
	To provide case management, homemaker, personal care and respite care to individuals who would require the level of care provided in a SNF or ICF. (Feb. 10, 1983).	Approved (July 15, 1983). Effective (Aug. 1, 1983).
	To provide case management, homemaker personal care, adult day health, habilitation, respite care and other services to patients who are medically or categorically eligible for medicaid assistance and who are certified for SNF or ICF care. (May 23, 1983).	Additional information requested.
Idaho	To provide minor physical modifications to the home, respite care services, day care, personal care services, attendant care, case management services, prescription drugs, nonmedically related transportation, and support services for residential care facilities to no more than 50 individuals who would be medicaid categorically eligible if institutionalized. Model Waiver. (June 10, 1983).	Additional information received.
Illinois (2 requests)	To provide adult day care, chore, homemaker, case management, home-delivered meals and transportation services to the aged and disabled. (Nov. 17, 1982).	Approved (June 17, 1983). Effective (July 1, 1983).
	To provide respite care, day program, and habilitation services to the developmentally disabled. (May 6, 1983).	Approved [2] (Sept. 14, 1983). Effective (July 1, 1983).
Indiana	To provide case management, homemaker services, home health aide services, respite care and care-giver, teacher/counselor services to categorically needy individuals age 65 or older in 16 county pilot areas. (July 5, 1983).	Additional information requested.
Iowa (2 requests)	To provide case management services to mentally retarded, aged and disabled beneficiaries. Initial implementation will involve Scott County. (Mar. 12, 1982).	Approved (May 7, 1982). Effective (Jan. 1, 1982).
	To provide case management services to indivuduals who qualify for SNF, ICF and ICF/MR services. (Dec. 2, 1982).	Withdrawn (June 8, 1983).
Kansas (3 requests)	To provide case management, homemaker, home health aide, personal care, adult day health, habilitation, respite care and hospice services to mentally retarded, aged and disabled beneficiaries. (Jan. 19, 1982).	Approved (Mar. 22, 1982). Effective (Mar. 22, 1982).
	To provide occupational, physical and speech therapy to individuals currently residing in adult care homes within five Kansas counties. (Jan. 25, 1982).	Withdrawn (Sept. 21, 1982).

PUBLIC LAW 97–35, SECTION 2176 WAIVER REQUESTS FOR HOME- AND COMMUNITY-BASED SERVICES—Continued

[All services will be provided as an alternative to institutional care]

State		Status
	To establish two intermediate care levels of services to be provided only to those individuals requiring less than ICF level of care currently being provided under the Kansas Medicaid plan. (Feb. 3, 1982).	Disapproved (Mar. 18, 1982).
Kentucky (3 requests)	To provide case management, homemaker, home health aide, personal care, adult day health, habilitation, and respite care services to mentally retarded beneficiaries. (Mar. 16, 1982).	Approved (Sept. 22, 1982). Effective (July 1, 1982).
	[3] Modification to waiver approved Sept. 22, 1982. Request to change reimbursement methodology and to change effective date from July 1, 1982 to Apr. 1, 1983. (Mar. 7, 1983). Approved May 6, 1983.	
	[3] Modification to modified waiver approved Sept. 22, 1982. Request to change effective date to July 1, 1983 and to require retrieval of durable medical equipment when reasonable and appropriate. (Aug. 4, 1983). Under review.[1]	
	To provide case management, homemaker, home health aide, adult day health, respite care, personal care services and minor home adaptations to aged and disabled beneficiaries. (Mar. 26, 1982).	Approved (Sept. 22, 1982). Effective (July 1, 1982).
	[3] Modification to waiver for the aged and disabled approved on Sept. 22, 1982. Request to require that SNF/ICF level of care determination be prepared by the Kentucky Peer Review Organization, to change the individual assessment forms and to change the effective date of the individual assessment forms and to change the effective date of the waiver to Mar. 1, 1983. (Jan. 10, 1983). Approved Mar. 31, 1983.	
	To provide adult day health care through adult day health centers to individuals who require a SNF or ICF level of care. (Mar. 25, 1983).	Additional information requested.
Louisiana (7 requests)	To provide homemaker, adult day health and habilitation services to mentally retarded, aged and disabled beneficiaries. (Nov. 24, 1983).	Approved (Jan. 6, 1982). Effective (Jan. 6, 1983).
	[3] Modification to waiver approved on Jan. 6, 1982. Request to exclude deeming for individuals using the three home- and community-based services (adult day care, homemaker and habilitation) approved for the Louisiana medicaid program. (Aug. 9, 1982). Approved Sept. 13, 1982; Effective Sept. 1, 1982.	
	[3] Modification to waiver approved on Jan. 6, 1982. Request to add an infant intervention program to approved waiver. (Mar. 29, 1983). Additional information requested.	
	[3] Modification to waiver approved on Jan. 6, 1982. Request to suspend provision of homemaker services from Mar. 1 to Aug. 31, 1983 because of lack of funds. Additionally, requests suspension of adult day health services. (Mar. 30, 1983). Additional information requested.	
	To provide substitute family care services, respite care services and supervised apartment care services to individuals who would otherwise require SNF or ICF services. (June 2, 1983).	Additional information requested.
	To provide group home/community home services to individuals who would be eligible for institutional services under 42 CFR 435.231 and who are now eligible under 42 CFR 435.232 (mentally retarded, physically handicapped, chronically mentally ill or substance abuse individuals). (June 2, 1983).	Additional information requested.
	To provide in-home services and personal care attendant services to individuals who would be eligible for institutional services under 42 CFR 435.231 and who are now eligible under 435.232. (June 2, 1983).	Additional information requested.
	To provide case management services to individuals who would otherwise require SNF or ICF services. (June 2, 1983).	Additional information requested.

PUBLIC LAW 97–35, SECTION 2176 WAIVER REQUESTS FOR HOME- AND COMMUNITY-BASED SERVICES—Continued

[All services will be provided as an alternative to institutional care]

State		Status
	To provide financial assistance and services to families for specific needs of a mentally retarded individual to remain at home or to return home from an out-of-home placement. (June 2, 1983).	Additional information requested.
	To provide adult day health services to aged and disabled beneficiaries. (July 7, 1982).	Approved (Oct. 1, 1982). Effective (July 1, 1982).
Maine	To provide habilitation, case management, respite care and transportation to ICF/MR eligibles. (Apr. 11, 1983).	Additional information received.
Maryland (2 requests)	To waive 1902(a)(1) and (23) and 1902(A) (10) and (13), (B) and (C) to furnish case management, residential habilitation, day care and transportation services to 669 MR/DD clients who are presently institutionalized in two ICF/MR's (Rosewood and Henryton State Residential Centers). (Oct. 21. 1982).	Approved (Mar. 4, 1983). Effective (July 1, 1983).
	To provide home- and community-based services which include: private duty nursing, home visits by specialty physicians, case management and medical equipment and supplies to no more than 50 individuals under age 18 who would be medicaid-eligible if institutionalized. Model waiver. (Sept. 13, 1983).	Under review.[1]
Massachusetts (4 requests)	To provide to the aged and disabled, home health, adult foster care, private duty nursing, respite care, personal emergency response system and individual assessments. (June 3, 1982).	Approved (Jan. 18, 1983). Effective (Jan. 18, 1983).
	[3] Modification to waiver approved on Jan. 18. 1983. Request to change effective date to July 1, 1983. (Feb. 17, 1983). Approved Apr. 15, 1983.	
	To provide to the mentally retarded, residential services, developmental day services, personal care, respite care, case management, environmental aids and transportation services. (June 3, 1982).	Withdrawn (Jan. 17, 1983).
	To provide personal emergency response system, homemaker services, orientation and mobility services, home residence adaptations, habilitation services, case management, residential care, sign language skills and family involvement services to the aged, blind and to developmentally disabled young adults. (July 21, 1982).	Additional information requested.
	To provide case management, personal care, adult day, residential, respite care, transportation, and adaptive services to individuals, who would require the level of care provided in an ICF/MR under medicaid. (July 13, 1983).	Additional information requested.
Michigan	To provide case management, personal care, private duty nursing, environmental modifications, extended home health services, psychosocial and respite care services to no more than 50 categorically needy and medically needy blind or disabled individuals under 21 who would otherwise require institutional care. Model waiver. (Mar. 29, 1983).	Approved (May 16, 1983). Effective (May 1, 1983).
Minnesota	To provide case management, homemaker, home health aide, personal care, adult day health, respite care services and foster care for the elderly, to aged and disabled beneficiaries. (Dec. 9, 1981).	Approved (July 23, 1982). Effective (July 23, 1982).
Mississippi	To provide case management services to no more than 50 disabled children age 18 or under who are institutionalized and require a SNF or ICF level of care and who would become ineligible due to deeming rules if they returned home (Model waiver). (Jan. 10, 1983).	Approved (Mar. 8, 1983). Effective (Jan. 13, 1983).
Missouri	To provide homemaker/chore services, adult day treatment, respite care and adult family home services to aged and disabled beneficiaries. (Feb. 26, 1982).	Approved (Apr. 22, 1982). Effective (Apr. 22, 1982).

PUBLIC LAW 97–35, SECTION 2176 WAIVER REQUESTS FOR HOME- AND COMMUNITY-BASED SERVICES—Continued

[All services will be provided as an alternative to institutional care]

State		Status
Montana (2 requests)	To provide case management, homemaker, adult day health, habilitation, respite care, nursing services, physical, occupational and speech therapy and psychologist services to mentally retarded beneficiaries. (Dec. 2, 1981).	Approved (Feb. 2, 1982). Effective (Feb. 2, 1982).
	To provide case management, homemaker, personal care attendant, adult day health, habilitation and respite care services to the elderly, physically handicapped and developmentally disabled. (Jan. 4, 1983).	Approved (Feb. 3, 1983). Effective (July 1, 1983).
Nebraska (3 requests)	To provide case management, homemaker, personal care, habilitation and psychiatric day services to mentally ill beneficiaries and case management, habilitation and transportation services to mentally retarded beneficiaries. (June 2, 1982).	Disapproved (Nov. 9, 1982).
	To provide multidisciplinary preadmission screening and assessment, case management, adult day health, chore and transportation services, respite care and living skills training services to individuals who qualify for SNF or ICF care and for whom a plan of care may be developed to meet the client's needs through in-home and community-based services. (Lancaster County) Model waiver. (July 5, 1983).	Additional information requested.
	To provide habilitation services and to allow for supportive intervention for the mentally retarded. (July 5, 1983).	Additional information requested.
Nevada (2 requests)	To provide case management and habilitation services to mentally retarded beneficiaries. (Mar. 1, 1982).	Approved (June 24, 1982). Effective (July 1, 1982).
	To provide case management, home health, personal care, respite care, nursing services, physical and occupational therapy, speech pathology, self-help devices, and minor home modifications, medical equipment and supplies to disabled persons eligible for placement in a SNF or ICF. (Nov. 9, 1982).	
New Hampshire	To provide case management, personal care, adult day care, habilitation and respite services in the community for the developmentally disabled at the ICF/MR level of care. (Apr. 19, 1983).	Additional information received.
New Jersey (3 requests)	To provide case management, habilitation, respite care, residential training and supervision and intervention services to mentally retarded beneficiaries. (June 7, 1982).	Approved (Dec. 28, 1982). Effective (Oct. 1, 1982).
	To provide case management, home health, medical day care, transportation, homemaker, social day care, pharmaceuticals and respite care sundries to eligible individuals. (Dec. 6. 1982).	Approved (June 8, 1983). Effective (Oct. 1, 1983).
	[3] Modification to waiver approved on June 8, 1983. Request to drop the payment of medicare part B premiums. (Sept. 14, 1983). Under review.[1]	
	To provide case management services to no more than 50 optionaly categorically needy blind and disabled children and adults who would otherwise be ineligible for medicaid while living at home in situations where earned and unearned income, including deemed income, exceeds the community living standard. Model waiver. (July 15, 1983).	Under review.
New Mexico (2 requests)	To provide case management, home care, adult day care and respite care for persons age 65 or older who are physically handicapped or blind; and would require care in a SNF or ICF; and may already be in a SNF or ICF; and for whom the home- and community-based services can be expected to be equivalent or less than the costs of institutional care; and who meet eligibility requirements. (June 6, 1983).	Approved (Aug. 12, 1983). Effective (July 1, 1983).
	To provide case management, habilitation, respite care and ancillary services to the developmentally disabled. (July 18, 1983).	Additional information requested.

PUBLIC LAW 97–35, SECTION 2176 WAIVER REQUESTS FOR HOME- AND COMMUNITY-BASED SERVICES—Continued

[All services will be provided as an alternative to institutional care]

State		Status
New York	To provide case management, respite care, medical social services, nutritional counseling, respiratory therapy, congregate meals, social day care, moving assistance, social transportation, housing improvement services, home maintenance tasks to aged and disabled beneficiaries. (Apr. 26, 1982).	Approved (Dec. 2, 1982). Effective (Dec. 2, 1982).
North Carolina (3 requests)	To provide in specified counties case management, homemaker, home health aide services, adult day health, respite care, chore services, preparation and delivery of meals, skilled nursing services and home mobility aids to aged and disabled beneficiaries. (Apr. 27, 1982).	Approved (Oct. 1, 1982). Effective (July 1, 1983).
	[3] Modification to waiver approved on Oct. 1, 1982. Request to add Person County to the list of counties providing services. (June 29, 1983). Approved (Sept. 8, 1983).[2]	
	To provide case management, homemaker, home health aide, personal care, adult day health, personal habilitation, respite care, and screening services, and home mobility aids and durable medical equipment to individuals eligible for ICF/MR care. (Nov. 30, 1982).	Approved (Feb. 22, 1983). Effective (Feb. 22, 1983).
	[3] Modification to waiver approved on Feb. 22, 1983. Request to change effective date from Feb. 22, 1983 to July 1, 1983. (June 29, 1983). Approved (Sept. 8, 1983).[2]	
	To provide case management statewide for children who would lose medicaid through deeming of parental income if they lived at home instead of in institutions. For persons in hospitals, SNF's, ICF's and ICF/MR's. (Model waiver) (Apr. 26, 1983).	Additional information requested.
North Dakota (2 requests)	To provide case management, homemaker, home health aide, personal care, adult day care, habilitation and respite care services to mentally retarded beneficiaries. (June 24, 1982).	Approved (Mar. 24, 1983). Effective (Apr. 1, 1983).
	To provide case management, homemaker services, home health aide services, personal care services, adult day care and respite care to elderly and disabled persons who would otherwise require care in title XIX—certified institutions. (July 8, 1983).	Additional information requested.
Ohio (2 requests)	To provide air-conditioner, cost of installation, strained baby food, strained fruit juice, canned formula, pager, parental transportation for hospital visits, transportation, and an in-home respite care worker 40 hours per month for Benjamin Kyle. Model waiver. (Aug. 22, 1983).	Approved [2] (Sept. 21, 1983). Effective (July 1, 1983).
	To provide home and community-based services which include: home health aide, homemaker/personal care/housekeeping, home-delivered meals, respite care, nursing care, physical therapy, nonroutine consumable medical supplies, adaptive and assistive equipment, and case management. Also requesting waiver of statewideness, comparability, option to exclude individuals on basis of excessive costs and freedom of choice. Eligible individuals are those determined by the Passport Assessment Team as requiring a level of care provided by an ICF on SNF facility, etc. (Sept. 1, 1983).	Under review.[1]
Oregon	To provide homemaker, housekeeper/chore services, nonmedical transportation, substitute living services, minor physical home adaptations and residential care facility services to mentally retarded, aged and disabled beneficiaries and case management, habilitation and respite care services to mentally retarded beneficiaries and personal care services to the mentally ill. (Nov. 18, 1981).	Approved (Dec. 23, 1981). Effective (Dec. 23, 1981).
Pennsylvania (6 requests)	To provide in specified counties case management adult day health, habilitation and transportation services, and physical, occupational, speech, visual and behavior therapies and minor adaptions to the residence to eligible individuals requiring ICF level of care. (Nov. 8, 1983).	Approved (May 27, 1983). Effective (July 1, 1983).

PUBLIC LAW 97–35, SECTION 2176 WAIVER REQUESTS FOR HOME- AND COMMUNITY-BASED SERVICES—Continued

[All services will be provided as an alternative to institutional care]

State		Status
	[3] Modification to waiver approved on May 27, 1983. Request to add 23 Pinehurst Center residents to the waiver to raise to total number of Philadelphia County beneficiaries to 123 in fiscal year 1984, 223 in fiscal year 1985, and 323 in fiscal year 1986. (Aug. 11, 1983). Additional information requested.	
	To provide case management, adult day health, habilitation, and other services to insure a beneficiary's optimal functioning in the community to mentally retarded persons who have been determined to require an ICF/MR level of care as defined by 42 CFR 440.150. (May 20, 1983).	Under review.
	To provide case management, adult day health and habilitation services in community living arrangements and in vocational rehabilitation facilities; therapy (physical or occupation, speech, visual and behavioral) services and minor physical adaptations to the CLA residences in Bucks County. (June 30, 1983).	Additional information requested.
	To provide adult day health and habilitation services in community living arrangements and in vocational rehabilitation facilities; minor physical adaptations to CLA residences and adult day care facilities; physical or occupational, speech, visual or behavioral therapies in Chester County. (June 30, 1983).	Additional information requested.
	To provide case management, adult day health and habilitation services in community living arrangements and in vocational rehabilitation facilities; transportation services; physical and occupational, speech, visual and behavioral therapy and minor physical adaptations to the CLA residences in Delaware County. (June 30, 1983).	Additional information requested.
	To provide adult day health and habilitation services in community living arrangements and in vocational rehabilitation facilities; transportation services; physical and occupational, speech, visual, and behavioral therapies and minor adaptations to the CLA residences in Montgomery County. (June 30, 1983).	Additional information requested.
Rhode Island (4 requests)	To provide case management, homemaker, adult day care services, devices to adapt home environment, minor assistive devices, and transportation to aged and disabled categorically needy individuals who are discharged from hospitals. (Mar. 1, 1982).	Approved (June 30, 1982). Effective (Jan. 1, 1982).
	[3] Amendments to waiver approved on June 30, 1982. Request to revise definition of statewideness to add persons discharged from an additional area hospital to the communities of Providence, Cranston, Johnston, and North Providence. (September 1, 1982). (Jan. 19, 1983).	
	To provide case management, adult day health and transportation services to the chronic mentally ill who would otherwise require ICF/SNF care. (Sept. 8, 1983).	Disapproved (Dec. 20, 1981).
	To provide to the mentally retarded case management homemaker, adult habilitation services, respite services, and, under certain circumstances, early intervention services, adult foster care, specialized homemaker services, devices to adapt the home environment, minor assistance devices and transportation. (Feb. 8, 1983).	Approved (Aug. 23, 1983). Effective (July 1, 1983).
	To provide case management, adult day health and transportation services to the chronic mentally ill who would otherwise require ICF/SNF care. (Feb. 4, 1982). (Resubmission of request disapproved on Dec. 30, 1982).	Approved (Apr. 25, 1983). Effective (Apr. 25, 1983).
South Carolina	To provide case management to aged and disabled beneficiaries. (Apr. 8, 1982).	Approved (Aug. 20, 1982). Effective (May 1, 1982).
	[3] Modification to waiver approved Aug. 20, 1982. Request to revise effective date from May 1, 1982 to Jan. 1, 1983. (June 17, 1983). Additional information requested.	

PUBLIC LAW 97–35, SECTION 2176 WAIVER REQUESTS FOR HOME- AND COMMUNITY-BASED SERVICES—Continued

[All services will be provided as an alternative to institutional care]

State		Status
South Dakota	To provide case management and habilitation services, dietary services, nursing services, psychological services, physicians' services, pharmacy and dental services, physical, occupational and speech therapy, audiological and optometric services, eyeglasses and transportation to mentally retarded beneficiaries. (Mar. 12, 1982).	Approved (July 6, 1982). Effective (June 1, 1982).
	[3] Modification to waiver approved July 6, 1982. Request to exclude deeming of income for individuals eligible for the home- and community-based services provided under South Dakota's approved waiver. (Oct. 26, 1982). Approved (Dec. 7, 1982).	
Tennessee (4 requests)	To provide home health aide services to aged and disabled beneficiaries. (Jan. 11, 1982).	Additional information requested.
	To provide a home- and community-based health care system to serve as an alternative to institutional long-term care in Shelby County. (Apr. 8, 1983).	Withdrawn (May 26, 1983).
	To provide case management, personal care, home health care, adult day care, respite care, transportation, medical equipment, home mobility aids and home-delivered meals to individuals requiring institutional care. (Apr. 25, 1983).	Additional information requested.
	To provide a home- and community-based health care system which will serve as an altenative to SNF/ICF in Shelby County, providing: case management, personal care services, respite care, nursing and therapy services, minor home modifications, DME, home-delivered meals and transportation. (May 26, 1983).	Additional information requested.
Texas	To provide medicaid home- and community-based services under 1915(c) of the Social Security Act. Limits services to eligible individuals residing in Potter or Randall Counties. (Jan. 18, 1983).	Approved (Apr. 14, 1983). Effective (Jan. 1, 1983).
Utah	To provide case management, homemaker, home health aide, personal care, adult day health, respite care, hospice services, medical alert and monitoring system, minor home modifications and night support services to aged, disabled and mentally retarded beneficiaries; and habilitation services to the mentally retarded. (June 8, 1982).	Approved (Oct. 20, 1982). Effective (Sept. 1, 1982).
Vermont	To provide case management, adult day health, habilitation and respite care services to mentally retarded and mentally ill beneficiaries. (Jan. 22, 1982).	Approved (June 23, 1982). Effective (Apr. 1, 1982).
Virginia	To provide personal care services to aged and disabled beneficiaries (May 17, 1982).	Approved (June 18, 1982) Effective (June 18, 1982)
	[3] Modification to waiver approved on June 18, 1982. Request to include a 1916(b) copayment waiver to exempt personal care recipients from copayments. (Apr. 20, 1983). Under review.	
Washington (2 requests)	To allow reimbursement for persons receiving home- and community-based care under a system called Community Options Program Entry System (COPES). (Aug. 16, 1982).	Approved (Dec. 17, 1982). Effective (Oct. 1, 1982).
	[3] Modification to waiver approved on (Dec. 17, 1982). Request to change effective date to Jan. 1, 1983. (Feb. 2, 1983). Approved Feb. 25, 1983.	
	To provide "Community Alternatives Program" to developmentally disabled people. (Mar. 30, 1983).	Additional information received.
West Virginia	To provide habilitation and respite care to the mentally retarded and case management, homemaker, home health aide, respite care, chore services, adult day care, adult family care, and personal care home support services and skilled nursing services to the aged and disabled. (Apr. 22, 1982).	Approved (Dec. 6, 1982). Effective (Dec. 6, 1982).

PUBLIC LAW 97–35, SECTION 2176 WAIVER REQUESTS FOR HOME- AND COMMUNITY-BASED SERVICES—Continued

[All services will be provided as an alternative to institutional care]

State		Status
Wisconsin	To provide case management, supportive home care, alternative care, and respite care to individuals who require an ICF/MR level of care. (Feb. 22, 1983). (Companion to 1915(b) waiver request received on same date).	Additional information received.

[1] Indicates new request.
[2] Indicates new approval.
[3] Indicates request for minor modification of an approved waiver—not counted as separate waive request.

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